Please enter your plan's contact information below using the examples to the right of each section.
As indicated in the cover memo sent with this survey, please complete the entire survey which consists of three (3) worksheets. The worksheets are entitled "DMHC Regulated", "CDI Regulated" and "PRODUCT TRENDS". Each worksheet can be accessed by clicking on the tab with the same name.
Should you have any questions or concerns regarding this survey, please contact Ralph V. Rodriguez at 916.445.0330.

		EXAMPLE
Plan Name:		All American Health Plans Corporation
Contact Name:		Jane Doe
Contact Address:		123 Any Street, Suite 100, Anytown, CA 95814
Contact Phone Number:		(916) 555-1212
Contact e-mail Address:		myname@mycompany.extension

GENERAL QUESTIONS	HMO COMMERCIAL			Medi-Cal	Healthy Families	Medicare + Choice	PPO COMMERCIAL		
	Individual	Small Group	Large Group				Individual	Small Group	Large Group
Percentage *of enrollment that has a prescription drug benefit as an integral part of a subscriber contract.*									
Percentage *of enrollment that has a prescription drug benefit as a rider to a contract.*									
Percentage *of enrollment that does NOT have prescription drug benefits.*									
For any products that do ***NOT*** *provide a prescription drug benefit, specify if your plan covers prescription drug necessary to provision of certain basic health care services.* ***(Examples:*** *Chemotherapy treatment or covered organ transplants.)*									
PRODUCT DESIGN ~ CO-PAYMENTS									
Does your plan offer products that include a prescription drug benefit subject to tiered co-payments? *If* ***YES*** *,*									
1. ***Percentage*** *of enrollment that has a prescription drug benefit subject to tiered co-payments.*									
2. Specify the number of ***tiers.***									
MAIL ORDER									
POINT-OF-SALE									
3. Specify the category of prescription drugs ***included*** *in each tier.*									
MAIL ORDER									
POINT-OF-SALE									
4. Specify the ***co-payments*** *for each tier.* *(If co-payments vary depending on subscriber contract, specify range of co-payments.)*									
MAIL ORDER									
POINT-OF-SALE									
5. Specify any and all ***deductibles*** *, including for each tier, if applicable.* *(If co-payments vary depending on subscriber contract, specify range of deductibles for each tier.)*									
MAIL ORDER									
POINT-OF-SALE									
Does your plan offer products that include a prescription drug benefit ***NOT*** *subject to tiered co-payments?* *If* ***YES*** *,*									
1. ***Percentage*** *of enrollment that has a prescription drug benefit* ***NOT*** *subject to tiered co-payments.*									
2. Briefly ***describe*** *prescription drug benefit.*									
PRODUCT DESIGN ~ DEDUCTIBLES									
Does your plan offer products that impose a deductible applied to all benefits, ***WITHOUT*** *a deductible specifically for prescription drugs?* *If* ***YES*** *,*									
Can expenditures for prescription drug benefits be ***applied*** *toward that deductible?*									
PRODUCT DESIGN ~ LIMITATIONS									
Does your plan impose limitations on prescription drug benefits? *If* ***YES*** *,*									
1. Maximum ***days' supply*** *per prescription.*									
MAIL ORDER									

POINT-OF-SALE									
*2. Maximum **quantity** per prescription.*									
MAIL ORDER									
POINT-OF-SALE									
*Specify any and all annual or lifetime **dollar** limitations imposed on prescription drug benefits.*									
PRODUCT DESIGN ~ MAXIMUMS									
*Does your plan offer products with an annual **out-of-pocket** maximum for all benefits? If **YES**,*									
*Can co-payments for prescription drug benefits be **applied** to this maximum?*									
Specify any and all annual out-of-pocket maximums for prescription drug benefits. (If maximums vary depending on subscriber contract, specify range of maximums.)									
PRODUCT DESIGN ~ EXCLUSIONS									
*Specify any and all drugs or classes of drugs that are **excluded** from annual or lifetime dollar limits.*									
*Specify any and all **excluded** drugs or classes of drugs. (Note: Do **NOT** list drugs or classes of drugs excluded from the formulary.)*									
*Specify specific **language** used to disclose such exclusions.*									

GENERAL QUESTIONS	PPO COMMERCIAL		
	Individual	Small Group	Large Group
Percentage of enrollment that has a prescription drug benefit as an integral part of a subscriber contract.			
Percentage of enrollment that has a prescription drug benefit as a rider to a contract.			
Percentage of enrollment that does NOT have prescription drug benefits.			
For any products that do **NOT** provide a prescription drug benefit, specify if your plan covers prescription drug necessary to provision of certain basic health care services. **(Examples:** Chemotherapy treatment or covered organ transplants.)			
PRODUCT DESIGN ~ CO-PAYMENTS			
Does your plan offer products that include a prescription drug benefit subject to tiered co-payments?			
If **YES**,			
1. **Percentage** of enrollment that has a prescription drug benefit subject to tiered co-payments.			
2. Specify the number of **tiers.**			
MAIL ORDER			
POINT-OF-SALE			
3. Specify the category of prescription drugs **included** in each tier.			
MAIL ORDER			
POINT-OF-SALE			
4. Specify the **co-payments** for each tier. (If co-payments vary depending on subscriber contract, specify range of co-payments.)			
MAIL ORDER			
POINT-OF-SALE			
5. Specify any and all **deductibles**, including for each tier, if applicable. (If co-payments vary depending on subscriber contract, specify range of deductibles for each tier.)			
MAIL ORDER			
POINT-OF-SALE			
Does your plan offer products that include a prescription drug benefit **NOT** subject to tiered co-payments?			
If **YES**,			
1. **Percentage** of enrollment that has a prescription drug benefit **NOT** subject to tiered co-payments.			
2. Briefly **describe** prescription drug benefit.			
PRODUCT DESIGN ~ DEDUCTIBLES			
Does your plan offer products that impose a deductible applied to all benefits, **WITHOUT** a deductible specifically for prescription drugs?			
If **YES**,			
Can expenditures for prescription drug benefits be **applied** toward that deductible?			
PRODUCT DESIGN ~ LIMITATIONS			
Does your plan impose limitations on prescription drug benefits?			
If **YES**,			
1. Maximum **days' supply** per prescription.			
MAIL ORDER			
POINT-OF-SALE			
2. Maximum **quantity** per prescription.			
MAIL ORDER			
POINT-OF-SALE			
Specify any and all annual or lifetime **dollar** limitations imposed on prescription drug benefits.			
PRODUCT DESIGN ~ MAXIMUMS			
Does your plan offer products with an annual **out-of-pocket** maximum for all benefits?			
If **YES**,			
Can co-payments for prescription drug benefits be **applied** to this maximum?			
Specify any and all annual out-of-pocket maximums for prescription drug benefits. (If maximums vary depending on subscriber contract, specify range of maximums.)			
PRODUCT DESIGN ~ EXCLUSIONS			
Specify any and all drugs or classes of drugs that are **excluded** from annual or lifetime dollar limits.			
Specify any and all **excluded** drugs or classes of drugs. (Note: Do **NOT** list drugs or classes of drugs excluded from the formulary.)			
Specify specific **language** used to disclose such exclusions.			

2002 to 2003

*As a **PERCENTAGE**, please indicate how much of your plan's premium is related to prescription drug costs.*

*As a **PERCENTAGE**, please indicate the increase or decrease in prescription drug costs to your plan.*

*As a **PERCENTAGE**, please indicate your plan's premium increase due to an increase in prescription drug costs.*

2001 to 2002

*As a **PERCENTAGE**, please indicate how much of your plan's premium is related to prescription drug costs.*

*As a **PERCENTAGE**, please indicate the increase or decrease in prescription drug costs to your plan.*

*As a **PERCENTAGE**, please indicate your plan's premium increase due to an increase in prescription drug costs.*

2000 to 2001

*As a **PERCENTAGE**, please indicate how much of your plan's premium is related to prescription drug costs.*

*As a **PERCENTAGE**, please indicate the increase or decrease in prescription drug costs to your plan.*

*As a **PERCENTAGE**, please indicate your plan's premium increase due to an increase in prescription drug costs.*

1999 to 2000

*As a **PERCENTAGE**, please indicate how much of your plan's premium is related to prescription drug costs.*

*As a **PERCENTAGE**, please indicate the increase or decrease in prescription drug costs to your plan.*

*As a **PERCENTAGE**, please indicate your plan's premium increase due to an increase in prescription drug costs.*